NOAA Health Services Aviation Questionnaire

Name: _____
Last First

Your E-Mail: _____
Your Phone: _____
SSN: _____

Birth Date: _____ Sex: _____ _____
(mm/dd/yr) M F

NOAA Program: _____
NOAA Supervisor: _____
NOAA Supervisor E-Mail: _____

Your Phone Numbers: _____ (W) _____ (H)

Emergency Contact: _____
Name Phone Relationship

GENERAL MEDICAL SCREENING

YES NO Do you have, or have you ever had: (explain any positive responses on Continuation Page)

1. **Disease of the eyes, ears, sinuses, seasonal allergies, hayfever, difficulty with clearing your ears, severe hearing loss, or pain in your ears or sinuses from diving or flying?**
2. **Chest pain, angina, heart attack, heart disease, heart murmur, palpitations, cardiac catheterizations, or pacemaker?**
3. **Hypertension, stroke, blood clots in legs, swelling in feet, or excessive fatigue with mild exertion?**
4. **Asthma, wheezing, emphysema, chronic cough, tuberculosis, collapsed lung, or shortness of breath with mild exertion?**
5. **Diseases of the bowel, ulcers, rectal bleeding, chronic abdominal pain, hernia, kidney stone, or painful or frequent urination?**
6. **Arthritis, joint deformity, chronic back pain, or limitation of use of your back or extremities?**
7. **Paralysis, weakness of muscles, seizures, epilepsy, migraine or other severe headaches, loss of consciousness, fainting spells, dizziness, or amnesia?**
8. **Mania, depression, schizophrenia, suicide attempt, alcoholism, illegal drug use, panic attacks, fear of flying, fear of heights, or fear of enclosed spaces?**
9. **Anemia, diabetes, cancer(s), arterial gas embolism, decompression sickness, severe motion sickness, surgery, hospitalization, or other chronic medical conditions not listed?**
10. **Are you currently pregnant?**
11. **Are you currently taking any medications?**

List Current Medications: _____ _____ _____
_____ _____ _____
_____ _____ _____

*****If you have been scuba diving within 24 hours of flying, have had any dental procedures within 48 hours of flying, or are currently pregnant – YOU MUST CONSULT WITH A FLIGHT SURGEON.**

Are you aware of any other medical condition(s) that may affect your suitability for aviation duty? No Yes
If yes, please explain on the continuation page

If you have any questions, please contact the appropriate Health Services Office:

Aircraft Operations Center: 813-828-3310 x-3102 (Office) / 813-294-6703 (Cellular)
Marine Operations Atlantic: 757-441-6320 (Office) / 757-615-6619 (Cellular)
Marine Operations Pacific: 206-553-8704 (Office) / 206-409-8725 (Cellular)
Director, NMAO Health Services: 301-523-7792 x-186 (Office) / 301-523-7792 (Cellular)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment. **ANY CHANGES IN YOUR MEDICAL CONDITION SINCE YOU LAST COMPLETED THIS MEDICAL HISTORY FORM, MUST BE REPORTED TO THE NOAA FLIGHT SURGEON IMMEDIATELY.**

_____ _____
Employee Signature Date (mm/dd/yy)

----------[Below section to be completed by NOAA Medical Officer]----------

MEDICALLY CLEARED FOR AVIATION DUTY BY HISTORY: YES NO NEED MORE INFO

_____ _____
AOC / MOA / MOP Regional Director of Health Services Date (mm/dd/yy)

Name: _____

NOAA Health Services Aviation Questionnaire Continuation Page